Pathways to Independence Acquired Brain Injury Services

APPLICATION FOR SERVICE

INSTRUCTIONS FOR COMPLETING APPLICATION FOR SERVICE

Upon receipt of your application and all required documentation, Pathways to Independence "Referral and Intake Committee" will review your request for service. The Committee (who meets monthly) will make recommendations regarding your request after which you will be notified in writing of the outcome.

To avoid a delay in processing your application, review the following checklist to ensure you have completed the necessary steps.

- Review criteria to ensure eligibility.
- Sign the Authorization to Release/Obtain Information. You or your Substitute Decision Maker must sign.
- Complete the Medical Status Form if you are unable to provide medical documentation to support your diagnosis of an acquired brain injury.
- Complete the Financial Disclosure section. The applicant or person legally responsible for financial decisions must sign.
- Please include all relevant documentation that supports the application and to assist in determining the needs and urgency.
- The applicant is encouraged to participate in the completion of this form as much as possible. This can be done in conjunction with a service provider and/or significant other. We would appreciate a copy of any documentation that supports the request and assists in identifying the specific needs of the applicant. Forms that are incomplete may be returned and will delay the application process

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APPLICATION FOR SERVICE FORM

PERSONAL INFORMATION			
First Name	Date of Birth DD MM YYYY		Sex: □ Male □ Female
Last Name			
Address (Inc Apt#)	Home Phone Number		Alternate Phone Number
City	Province	Postal Code	Email Address
Health Card Number			
Do you wear a medical alert bracelet? □ Yes □ No		Marital Status	
Current Living Situation: □ Alone □ with other (specify) ______________________________			
Accommodation: □ house □ group home □ apartment building □ supportive housing □ rooming house □ long term care facility □ hospital □ other ______________________________			
Citizenship: □ Canadian □ Permanent Resident □ Other			
Are you a resident of Ontario? □ Yes □ No If yes, how long? ______________			
Language Spoken:		Interpreter Required: □ Yes □ No	
First Nation Band Affiliation:		Status Number:	

BRAIN INJURY INFORMATION					
Date of Injury DD MM YYYY		Cause of Injury (e.g. anoxia, assault, motor vehicle collision, fall, etc.)			
Family Physician			Treating Emergency Hospital		
City	Province	Postal Code	City	Province	Postal Code
Telephone			Telephone		
Is there history of a previous injury/accident: □ Yes □ No					
If yes, please explain:					

PERSONAL SUPPORT NETWORK / EMERGENCY CONTACT			
Name		Relationship	Contact Person □ Yes □ No
Address (inc. apt #)			Home Phone
City	Province	Postal code	Work Phone
Email Address			

REFERRING AGENT			
Name		Relationship	Contact Person □ Yes □ No
Address (inc. apt #)			Home Phone
City	Province	Postal code	Work Phone

PROGRAM REQUESTED
Supported Independent Living Services
Community Services/Outreach
Day Program
Respite
Residential (24 hour)
Employment

REASON FOR REFERRAL
Applicant/SDM:
Referring Agency

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TREATMENT HISTORY(if applicable) ◻ Yes ◻ No If Yes, please complete the following:		
Program/Facility/Hospital	**Dates Involved (DD MM YYYY)**	**Contact Name and Phone Number**

Are you receiving or have you applied for other brain injury services? ◻ Yes ◻ No	
If yes, please provide contact names and phone number:	
Have you participated in a neuropsychological assessment? ◻ Yes ◻ No	
If yes: Name of Assessor:	Phone Number

NOTE: Medical, attendant care, rehabilitation and vocational reports are required (if available) such as: Neurosurgery, Neuropsychology, Speech Therapy, Physiotherapy, Occupational Therapy, Social Work, Psychology, Psychiatry, Assessment and Discharge Summaries. Please attach copies of any available reports to this application.

MEDICAL INFORMATION
Seizures ◻ Yes ◻ No If yes, If yes please describe type and frequency: ____
If applicable, are your seizures under control? ◻ Yes ◻ No
Wheelchair ◻ Yes ◻ No ◻ Manual ◻ Motorized Transfers ◻ Independent ◻ Stand-by assistance ◻ Full assistance
Supervision or assistance with mobility: ◻ Yes ◻ No If yes, does it apply to ◻ level surfaces ◻ stairs ◻ both
Communication Issues ◻ Yes ◻ No If yes, please describe: ____

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Cognitive Difficulties (memory, concentration) ☐ Yes ☐ No

If yes, please describe:

____

Other physical conditions (allergies, diabetes, heart conditions, diet restrictions, etc.) ☐ Yes ☐ No

If yes, please describe:

____

Have you ever experienced behavioral that is challenging, for example- mood disorder, anxiety, social isolation, anger management? ☐ Yes ☐ No

If yes, please describe:

____

LIST OF MEDICATIONS (if you need more space please write on back of this page)

Name of Medication	Dosage	Times taken

Do you self-medicate? ☐ Yes ☐ No

PSYCHIATRIC

Do you have a psychiatric diagnosis? ☐ Yes ☐ No

If yes. Date/Year of Diagnosis: ______________________________

Nature of diagnosis: ____

Psychiatric consult notes: ☐ Included ☐ Report to follow ☐ Not available

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SUBSTANCE ABUSE / LEGAL			
Pre-Injury History of Substance Abuse:	□ Yes	□ No	□ History not available
Current Substance Abuse:	□ Yes	□ No	□ Not known
If Yes, Substance Abuse Treatment Recommended:	□ Yes	□ No	
Are you presently undergoing treatment for addictions?	□ Yes	□ No	
Is there any history of criminal charges/probation?	□ Yes	□ No	
If yes, please describe: ________________________________			

EDUCATION AND EMPLOYMENT		
Name of Last School Attended:	Address of School:	
Level Attained:	Year Completed:	
Name of Last Employer:	Position:	How long?

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FINANCIAL INFORMATION ***This section must be completed by the applicant or person responsible for financial matters.***

Check Source Of Income:

□ Ontario Disability Support Program (ODSP) □ Ontario Works (OW)

□ Old Age Security (OAS) □ Canadian Pension Plan (C.P.P.)

□ Workplace Safety Insurance Board (W.S.I.B.) □ Long Term Disability (private)

□ Lawyer's Name: **(if applicable)** ______________________________

Company: ______________________ Phone: ______________________

□ Insurance Adjuster Name: **(if applicable)** ______________________________

Company: ______________________ Phone: ______________________

□ Rehabilitation Case Manager Name: **(if applicable)**______________________________

Company: ______________________ Phone: ______________________

□ Insurance Settlement □ Structured Settlement □ Inheritance □ Part Time Employment

□ Full Time Employment □ Income Generating Assets - please describe: ______________

Amount of income per month: __________ Do you have direct access to your income? □ Yes □ No

If no, Name and Phone Number of Substitute Decision Maker/Power of Attorney:________________

Do you make your own personal decisions? □ Yes □ No
If no, Name and Phone Number of Substitute Decision Maker/Power of Attorney:________________

____

I, ______________________ certify that the above mentioned information is correct, to the best of my knowledge.

______________________________ ______________________________
Signature date

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize ____

(Name of organization releasing information)

To release to, and/or obtain from:

____

____

Information from relevant client records, in accordance with the policy(ies) of the originating organization regarding:

____

(Name of Client) (D.O.B)

The required information to disclosed/obtain shall include written and verbal information regarding diagnosis, rehabilitation and support services needs as outlined in my application for services.

This authorization shall be valid from ________________ to _________________ and does not permit further disclosure without my specific written consent

___________________________________ ___________________________________

(Applicant) Date Witness Date

____

(Substitute Decision Maker) Date

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Medical Status Form

(Must be completed by a medical doctor)

___________________________________ is applying to Pathways to Independence Acquired Brain Injury

(Name and date of birth)

Services. In order to process the above named persons application, this form must be completed in full.\

This form is to be completed by a medical doctor and submitted with your application if you do not have any other medical documentation to support your diagnosis of an acquired brain injury.

Physical Status

Does the applicant require assistive devices? ☐ Yes ☐ No

If YES, please describe:

Does the applicant require attendant care? ☐ Yes ☐ No

If YES, please explain:

Are there any physical conditions that should be known? ☐ Yes ☐ No

If YES, please describe:

Medications

Name of Medication	Dosage	Reason	Side Effects

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Diagnosis

Is the applicant's **primary** diagnosis an acquired brain injury? □ Yes □ No

If NO, please specify primary diagnosis:

Is the injury progressive or degenerative in nature? □ Yes □ No

Please specify diagnosis:

Is there a secondary and/or a dual diagnosis? □ Yes □ No

If YES, please specify:

Date of Application:___________________________________

____ _______________________________

Physician's signature or Stamp: Date

Please return form to:

For Ottawa:
Pathways to Independence
356D Woodroffe Ave.
Ottawa, ON K2A 3V6
Attention: Kerry Tilden

For Belleville:
Pathways to Independence
289 Pinnacle St.
Belleville, ON K8P 3B3
Attention: Connie Gorring

Form created May 14, 2013